The Hampden Hippocrat

A Bulletin for the Hampden District of the Massachusetts Medical Society

VOLUME V AUTUMN, 1946 Number 3

Secretary's Annual Report

Three meetings of the Hampden District Medical Society have been held since the annual session of May 8, 1945. On October 30, 1945, the change of meeting time from afternoon to evening was inaugurated when Dr. Richard B. Cartell of Lahey Clinic spoke on "Obstructive Jaundice". January 29, 1946, Dr. James A. Evans of Lahey Clinic discussed "Hypertension: Modern Surgical Treatment from the Viewpoint of the Internist". Tuesday evening, March 26, 1946, Dr. Richard H. Overholt, thoracic surgeon of Boston presented "Silent and Masquerading Chest Lesions".

Reprints of the papers presented at the Post-Graduate Medical Assembly held February 5, 1946 at Springfield Hospital were distributed by the Society.

During the past year the following seven members were lost by death:

Dr. Wallace L. Chesbro, Dr. Fred Fay Dexter, Dr. Thomas H. Greenway, Dr. Henry L Hirsch, Dr. Edward A. Knowlton, Dr. George A. Moore, and Dr. William H. Morrison.

In addition to several members who came to us by transfer, the following were admitted:

Dr. Charles Bilodeau, Dr. Edward J. Ferrarone, Dr. Max Reinisch, Dr. Joseph Rini and Dr. Edward G. White.

Officers, 1946-1947

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Hampden Hippocrat

"Life is short and art is long, the occasion fleeting, experience fallacious and judgment difficult." —Hippocrates, 430 B.C.

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As of today, April 30, 1946, the Hampden District Medical Society has a total Membership of 363. Of these about 315 are in active home pactice; roughly 35 men remain in Military service. Retired members number 13.

The Society welcomes back to local fellowship the many members who have served in the armed forces.

Edward Abbott, J. R. Agnew, Fred Allen, Jr.

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William Teahan, Herbert Toombs John W. Turner.

George Vassos, Jr.

Jacob Weisman, Austin E. Whitcomb, Walter W. Williams, Frank B. Wisner.

Edmund J. Zielinski.

Appeared in the Sunday Union-Republican, June 23, 1946.

Signed—George C. Steele.

Dentists & Surgeons Supply Co.

340 Bridge Street

Springfield Massachusetts

Hampden Hippocrat Supplement

Continuation of Comments from Page 8

Question number 16. The answers to this question are discouraging to men like Dr. Gallupe, who as secretary to the Board of Registration in Medicine and a driving force in Massachusetts Medical practice, is trying to work out a way so that implied promises made to unapproved school men that they might not continue their opposition to a single standard of medical education in Massachusetts will be fulfilled. The report on hospital bed study in this issue and lack of room for more doctors to have hospital facilities is one fair answer to the slowness of the progress of the Gallupe Plan. Those in responsible places, however, must do their full share towards a united front in Massachusetts Medicine. The Federal Medicine forces against us, one and all, will gladly welcome and freely use any lack of interest and energy on our part.

Question number 17. The answer to this question are clear cut.

Question number 18. Apparently many hospitals do not open their pathological conferences to any great number of unapproved school men. It would seem this would not be much of an effort to attempt.

Qutsions 19 and 20 are one rather than two. It is evident from the replies received that the urge of seniors to send juniors to war with implied promises that when they return they would be received with open arms, are now amended to a considerable degree by qualifications which many of those who make these amendments do not themselves possess.

Does Springfield Have Enough Hospital Beds?

Now is the time when various organizations, business firms, municipalties and the like are taking account of stock, making surveys of present and foreseeable needs, and planning building programs. It has been fifteen years since there has been any increase in the bed capacity of the general hospitals in Springfield. In order better to ascertain our current needs, it seemed worthwhile for the Hippocrat to compare the situation in this community with those existing elsewhere in cities comparable to Springfield either because of their size or their proximity The statistics assembled here are derived from records compiled by the American Medical Association, and for our particular purpose deal only with general hospital beds; inasmuch as specialized institutions, for example tuberculosis or mental hospitals, have problems peculiar to themselves. Naturally military installations and veterans facilities were excluded.

In order to compare different communities, a ratio was made by dividing the population by the number of beds available. The ratio, therefore, indicates the number of people in a city per general hospital bed. For example, in Springfield there are 149,554 people and 708 general beds, or 211 persons per bed. Population figures are based on the 1940 census, bed figures are accurate to 1946.

First suppose we consider all the cities in New England with populations ranging between 100,000 and 200,000. There are ten of them, all in Massachusetts and Connecticut. Table 1 shows that Springfield ranks 7th on this list.

Because of our poor standing locally it seemed worth while to make a similar comparison on a nationwide basis. Table 2 lists all of the cities in this same population group—100,000 to 200,000—in the United States. It is noteworthy that out of 49 cities we rank 35th, which is no better than our standing in New England. It is also notable that of the 14 cities lower on the list than we, four ot them, namely Long Beach, Gary, Yonkers, and Somerville are really satellite towns for Los Angeles, Chicago, New York and Boston all of which are medical centers providing the bulk of the hospitalization for adjacent areas. And finally it is signifcant that the three cities which we manage to outrank in the New England group are the three worst in the entire United States.

Now let us turn our attention once more to New England. Because a large metropolitan area has so many interdependent functions including hospitalization, it is difficult to make comparisons with other municipalities which are farther apart and more self sufficient. For that reason the next table (Table 3) is made up as follows: draw a line north and south across Massachusetts running thro Framingham and disregard that part of the state east of this line. Now consider all the rest of New England except this eastern Massachusetts area. This time the table contains all the cities in the designated region with a population of 40,000 or more. There are 14 such and now Springfield ranks 12th. The position of Providence is difficult to explain, but there is no question in regard to New Britain that the trend of hospitalization is into Hartford.

It is, of course, quite impossible to rate cities scientifically purely on a basis of population and available beds. As we have pointed out, some cities are medical centers and have large bed capacities, others are near medical centers and have small bed capacities.

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Different areas have different problems and allowances have to be made for such. Although it is unfair to alter the figures in one instance without doing so in all, it is difficult to see how many allowances would make our position more favorable. Rightfully, Chicopee, which has no hospital, should be included in the Springfield population. A sizeable percentage of the "general" hospital beds in Springfield are actually devoted to patients receiving chronic care. Both of these factors, if taken into account would worsen our position. It all boils down to the fact that within 15 miles of the Campanile there dwell one-third of a million people whose provision for hospital beds is almost the worst in New England.

TABLE 1

	City	Ratio of Pop. Hosp. Beds
1	Hartford	124
2	New Haven	143
3	Cambridge	173
4	Worcester	176
5	Bridgeport	203
6	Lowell	205
7	SPRINGFIELD	211
8	Fall River	265
9	New Bedford	333
10	Somerville	844

Cities listed are those in New England with population ranging from 100,000 to 200,000.

TABLE 2

	City	Ratio of Pop. Hosp. Beds
1	Wichita	113
2	Charlotte, N. C.	114
3	Sacramento	117
4	Hartford	124
5	Utica	127
6	Wilmington, Del.	129
7	Peoria	129
8	Salt Lake City	135
9	Tacoma	135
10	Richmond, Va.	139
11	Tampa	142
12	New Haven	143
13	Kansas City, Kans.	147
14	Nashville	149
15	Spokane	151
16	Patterson	156
17	Albany	157
18	Norfolk	162
19	Duluth	172
20	Cambridge	173
21	Trenton	173
22	Knoxville	175
23	Worcester	176
24	Reading, Pa.	180
25	Camden, N. J.	182
26	Scranton, Pa.	184
27	Elizabeth, N. J.	189
28	Fort Worth	197
29	Miami	197
30	Youngstown, O.	202
31	Bridgeport	203
32	Lowell	205
33	Fort Wayne	205
34	Tulsa	210
35	SPRINGFIELD	211
36	Des Moines	217
37	Flint, Mich	218
38	Yonkers	220
39	Long Beach, Cal.	224
40	Gary, Ind.	227
41	Jacksonville, Fla.	227
42	Canton, O.	232
43	Erie, Pa.	238
44	Grand Rapids	238
45	South Bend, Ind.	246
46	Chattanooga	259
47	Fall River	265
48	New Bedford	333
49	Somerville	344

The cities listed are those in the United States with populations ranging from 100,000 to 200,000.

TABLE 3

	City	Ratio of Pop. Hosp. Beds
1	Portland, Me.	100
2	Hartford	124
3	Pittsfield	128
4	Stamford	133

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5	New Haven	143
6	Waterbury	156
7	Holyoke	174
8	Worcester	176
9	Fitchburg	190
10	Bridgeport	203
11	Manchester, N. H.	206
12	SPRINGFIELD	211
13	Providence	241
14	New Britain	312

Cities listed are those in New England, with the exception of eastern Massachusetts, with a population of over 40,000.

Mass. Hospital Study

When one hears statements made about the relative efficiency of hospital staffs, how other hospitals do better or worse, what standards govern staff appintments, and a half dozen other enlightening or embarassing assertions, it becomes fitting that a report of a study such as the following be instituted by a county medical society organ in our state. Such an instrument is the Hampden Hippocrat.

Twenty-one hospitals of like function were contacted by our office. Of these all but one answered the questions sent them, and that one forwarded its bulletin out of which some information was gathered. Many of these hospitals showed a keen interest in this project and await this summary. It is a pleasure to engage in a query such as we have undertaken, and we hope that individual courage may be engendered against those national studys and surveys which overcome us now and then.

We find in this study a peculiar individuality of staff organization depending very much on the leadership, geography and peculiar factors governing the community and the hospital in its midst.

There is no single standard of staff organization in this report. There is a similiarity though, a divergence of nomenclature, yes, but all in all, all the staffs appear to be strong, trustworthy, and quite able to serve the patient and the doctor in a mutually satisfactory manner. The following hospitals were contacted in this survey and are noted as follows, with their listed bed capacities.

Worcester City Hospital	480
Mercy Hosp., Springfield	315
St. Luke's, New Bedford	294
Springfield Hospital	281
St. Vincent's, Worcester	242
Newton-Wellesley	252
Lynn	242
Salem	236
Cambridge	221
Burbank, Fitchburg	220
Malden	217
House of Mercy, Pittsfield	189
Memorial, Worcester	185
Lawrence	183
Providence, Holyoke	168
Peverly	166
Truesdale, Fall River	165
Union, Fall River	165
Lowell	158
Waltham	144
Holyoke	140

Summary of Staff and Hospital Organizations in Twenty-One Hospitals, Ranging from 140 beds to 480 beds in Massachusetts outside of the Center of Boston:

1. Type of Hospital?

General and obstetrics, 16; general and obstetrics and contagious diseases, 1; general and obstetrics and chronic, 1; general and obstetrics and T. B., 2; general and chronic, 1.

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2. Are doctors appointed to board of directors as members, independently of Staff?

Yes, 2; No, 17; Yes, Surgeon in Chief, 1; Yes, 1; on Staff formerly, now appointed to Board.

3. Do you have elected Staff representatives as members of your Board of Directors or Trustees?

Yes, 6, elected by Staff.
Yes, 1, Secretary of Staff.
Yes, 2, Chief of Staff.
Yes, 1, President of Staff.
No, 9.

One Hospital has its executive Board invited to important meetings of trustees.

Chairman of Executive Committee of Staff, Yes, 1.

4. Do you have a chief of Staff? Yes, 10; No. 6; Yes, 2, called president; 3, no answer. Is he a teacher at a medical school? 13 no; 3, yes; 5 no answer.

5. Do you have chiefs of sections? Yes—15; No. 3; Some—2. Are they teachers? Yes—1. No—10. Some—4. Supposed to be—1. No answers 5.

6. Do you require board certifications at any point? Yes—10. No—11. FACS? Yes—5. Balance—no answer. FACP? Balance no answer. One Hospital reports that 50% of work in speciality constitutes specialists.

7. Do you require specialists as heads or members of services? Yes—16. No 3. Balance—no answer.

8. In demanding board certification do you set a date of medical school graduation after which it is required? No 8. Starting now, yes, 1. No answer 10. One answers "yes by attrition". One answers, "no not for men in practice before boards came in."

9. Do you have written staff by-laws? Yes—17. No.—1. Balance, no answer.

10. Do you have a staff executive committee, Staff Council, Advisory Committee, Efficiency Committee? If so, how appointed? Yes—12. Elected. No. 1. Yes—Chief and 1. Chiefs 1. Chiefs of Services and 2 others, 1. Officers and 2 others, 1. Officers and three others, 1. 2 officers elected. 1.

11. Do you have an honorary or an emeritus staff designation? Yes, 15. No. 6.

12. Are your staff appointments from the staff of trustees? By trustees 4. By trustees on recommendation of Staff—16. By Staff, 1.

13. What is the number of your medical and surgical services and duration? No answer—8. Two months—5. Two and three months—1. Three months—2. Medical two months, surgical alternate each month—1. Seven medical and eight surgical each year, 1. Two answer twelve months services, split up among subordinates. Medicine two and three months. Surgery one year—1. Balance no answer.

14. What is your age retirement from active service and chiefship? None—5. No answer—1. Being considered, 1. Sixty-five—5. Sixty-three—3. Sixty-two—1. Sixty—1. Sixty-surgical and sixty-three medical—1. Sixty surgical sixty-two medical—1. Balance no answer.

15. Do you have a disaster organization? No—11. Yes—8. Balance no answer.

16. Are you doing or contemplating doing anything with the Gallupe Plan? No—6. Yes—1. Yes in part—2. Plan to—10. No answer—2.

17. Are any unapproved school men on your actual staff? Yes—4, No—15. No answer—2.

18.Do you select some of these who can bring cases in and attend pathological conferences? Yes—10, No—4, No answer—balance.

19. Is your tendency toward opening up staff for returning veterans or—No—2. Yes—2. Yes if qualify—5. Balance—no answer.

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20. Is your tendency toward limiting responsibility only to those men best qualified for it, thus raising the standard of the hospital rather than to use as yet uncertified men? Yes—14. Balance no answer.

Some Comments

Question 1 was easy to summarize.

Question 2, which was asked because of the material found on page 16 of the latest American College of Surgeons Hospital Standardization Bulletin, is not as comprehensive in its summary as a more extensive inquiry would bring out.

Question 3 brought out the fact that several hospitals have no doctors on their board of directors but that there is a liason committee which is consulted on staff matters by the trustees

Questions number 4 and number 5 bear out the contention that the nearer to a medical teaching center a hospital is, the more likely satisfactory chieftainships will be set up. In some cases also it is noted that where outstanding medical men are repsonsible for the development of a particular hospital away from a medical center, these men bring in from outside certain younger material with the definite intention of having them fill their seniors' positions. A paragraph from the letter from one such hospital is of interest.

"Most men who settle in this area are aware of our hospital standards and the unlikelihood of receiving anything more than an appointment to the Courtesy Staff.

"I think I have mentioned before that when we have the need of extra members on our staff we very generally import men of thorough training rather than fill gaps with local men who are not qualified."

Question number 6 is interpreted by most of the replies by amendments to them, meaning that the hospital itself determines the qualifications of the men as they know them.

Question number 7 is clear in its answer as stated.

Question number 8 in most cases is clear. Apparently those who are already on a staff are charged from then on to do the work and presumably to establish board certification at some later date if possible. One hospital reports that "board certification will be required in the future. This requirement is not retroactive." This seems to be the fairest answer in the lot.

No one yet has seemed to see that a span of years reaching perhaps to twenty-five will very often elapse between the date of graduation of those older men who came into certification through an open door, membership in established socities, or otherwise, and in the date of graduation of the most recent group for whom facilities for specialization and board certification have been set up.

To be thoroughly consistent, if board membership is a prequisite to heads of services or heads of departments, those who give it lip service might well see to it that our very recent graduates who have this certification be put in as chiefs of services and that the twenty-five year span men previously mentioned accept this as progress and thus maintain intellectual honesty of a stand which without amendment has been taken by many in authority.

Another viewpoint might be, that taking the year 1940, or some like year, only graduates of medicine be required to have board certification

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after that date to be made heads of departments and sections.

Question number 9. Of course a staff which has no written by-laws really has no responsibility.

Question number 10. Whatever a hospital chooses to call it, most every hospital has a connecting link between the staff and trustees. They are called by different names, some of them are fixed for long terms and some of them are in part or all elected. From the replies, it can be deducted that for those hospitals which have a very superior outstanding personality in medicine, who has either built the hospital up or holds the key position in the community; these institutions are inclined to have a more arbitrary and less elastic connecting link.

Question number 11. The affirmative answers to this question were a surprise.

Question number 12. Almost all of these answers showed that the staff recommended and the trustees appointed staff members.

Question number 13. The answers to this question were sometimes confused and it is apparent that in some hospitals one man runs his service for an entire year and delegates the actual work to subordinates. Most hospitals, however, have a two month or three month service and the responsibility is confined to the directors of those periods.

Question number 14. Here is found a great variation in retirement age. Apparently some men lose their supreme usefulness at 60 and others never lose it.

Question number 15. It would seem that a permanent disaster organization is inclined to follow rather than anticipate a need. Civilian defense came after the nation got into trouble. The Hartford fire and the Coconut Grove disaster stimulated work in those areas.